GLENHAVEN
DENTAL HEALTH | FACIAL AESTHETICS | IMPLANT CENTRE

# CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

**To obtain the best and safest treatment, your Dentist needs to know of any problems which may affect your treatment. This form is a legal requirement.**

## Personal Details

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms  Sex ☐ M ☐ F

Full Name

D.O.B  / /

Home Tel.

Email Address

Occupation

Mobile Tel.

Home Address

Postcode:

Approx. date of last dental visit  / /

Work Tel.

Doctors Name and Address

## Medical History – Do you have or have you suffered from – tick only those that apply

- ☐ Allergies
- ☐ Angina
- ☐ Asthma
- ☐ Chest problems
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Excessive bleeding after extractions
- ☐ Fainting attacks
- ☐ Heart murmur
- ☐ Heart Problems
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever

### Have you had any of the following?

- ☐ Bad Reaction to General or Local Anaesthetics
- ☐ Taken Steroids in the last 2 years
- ☐ Diagnosed or Suspected VCJD
- ☐ Had a Joint Replacement
- ☐ Recent Blood Tests
- ☐ Diagnosed or Suspected HIV+

### Relevant Information regarding any ticked above:

### Are you:

- ☐ Seeing your Doctor at present
- ☐ Carrying a Warning Card
- ☐ Pregnant - Due date  / /

### Do you:

- ☐ Currently Smoke
- ☐ Drink Alcohol

### How many per day:

### How many units per week:

### Please provide details of any medication you are taking:

COMPLETED BY SELF/ PARENT/ GUARDIAN/ OTHER (Please delete where appropriate)

I agree to inform my Dentist immediately if my medical condition changes from any of the above

SIGNATURE…….  DATE……